Supervising Physician's Name (OD,MD,DO only)	DEA#	Phone#	Fax#
Practice Name & Address	City	State	ZIP

Patient Name	DOB	Phone#	
Patient Address	City	State	ZIP

ELC MEDICAL

Bill & Ship to Patient Only

Fax to: 866-635-2329

Atropine Ophthalmic Solution

Atropine 0.01% Ophthalmic Solution

Instill 1 drop into ❑ OS ❑ OD ❑ OU every night at bedtime.

❑ 3 x 3.5mL Vial (3 month supply)

Refills: _____ ❑ 1 ❑ 2 ❑ 3 ❑ NR

Special instructions:_____

_____

Prescriber's Signature (OD,MD,DO only)	NPI #	Date

All signatures must be unique (no stamps or photocopies).
Innovation Compounding makes no claims of safety and/or efficacy as these compounded products have not been evaluated or approved by the FDA.

06/18

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